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No. 08-501

IN THE

Supreme Court of the United States

PRISCILLA GLAZER,

Petitioner,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Eleventh Circuit erred in holding, in conflict with several Circuits and in apparent conflict with the Department of Labor's expressed position, that an ERISA administrator is not required to provide a participant with access to new evidence it develops after a participant's only administrative appeal has been submitted in response to a denial of plan benefits, nor the opportunity to review and respond to this new evidence, prior to the closure of the administrative record.

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Petitioner-Plaintiff, Priscilla Glazer, respectfully submits that a writ of certiorari should issue to review the April 21, 2008 decision of the United States Court of Appeals for the Eleventh Circuit entered in this case.

OPINION BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit affirming the decision of the United States District Court for the Southern District of Florida is reported at 524 F.3d 1241, and is reproduced in the Petitioner's Appendix. Pet. App. A. The opinion of the District Court is not reported and is reproduced in the Appendix. Pet. App. B.

JURISDICTION

The judgment of the Court of Appeals was entered on April 21, 2008, and the Eleventh Circuit denied Petitioner's request for a rehearing in an order filed on June 13, 2008, which is reproduced in the Appendix. Pet. App. C. The time for filing this petition was extended by Justice Thomas to October 11, 2008. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The section of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), involved provides in pertinent part:

> In accordance with regulations of the Secretary, every employee benefit plan shall—
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133.

The pertinent Department of Labor ("DOL") Regulation involved, ERISA Claims Procedure, 29 C.F.R. § 2560.503-1 (2000), is reproduced in pertinent part in the Appendix. Pet. App. D.

STATEMENT OF THE CASE

A. Factual Background

Priscilla Glazer worked for several years as a senior technical writer for The Ultimate Software Group ("Ultimate"). As a benefit of her employment, Glazer chose to participate in the Ultimate Long-Term Disability Plan ("the Plan") insured and administered by Reliance Standard Life Insurance Company ("Reliance Standard"). The Plan is governed by ERISA.

At the advice of her treating Orthopedist, Glazer ceased working on June 13, 2003, and subsequently filed a claim for disability benefits with Reliance Standard under the Plan. On January 13, 2004, Reliance Standard found that Glazer became disabled under the terms of the Plan as of June 13, 2003 and approved benefits. Glazer continued to present information from her treating doctors, including her Orthopedist, Physiatrist, Rheumatologist, and Internist, which included documentation of her chronic and severe medical condition and limitations, opinions that Glazer was disabled from working, and advisements that she had reached maximum medical improvement. In May 2004, Glazer's treating Physiatrist completed a Physical Capacities Questionnaire form ("PCQ") at Reliance Standard's request. While Glazer's Physiatrist indicated on the PCQ that Glazer was capable of performing some basic sedentary level activities, he did not state that Glazer's condition had improved, and did not opine she was able to perform the substantial and material duties of her regular occupation on a full or part-time basis.

On July 11, 2004, without consulting a medical professional regarding the Physiatrist's PCQ and Glazer's medical file, Reliance Standard terminated Glazer's disability claim. Reliance Standard asserted that based upon the Physiatrist's PCQ and a previous interview with Glazer, she was capable of performing "sedentary duty classification" on a full-time basis. In response, Glazer submitted her only administrative appeal allowed under the Plan, providing evidence to refute Reliance Standard's stated rationale for termination of her disability income benefits.

In a May 12, 2005 letter, Reliance Standard upheld its denial based upon the following expert reports generated by it without Glazer's knowledge following the submission of her appeal: three (3) medical reviews and reports totaling fifteen (15) pages by a Gastroenterologist, Dr. Hauptman, hired by Reliance Standard ("the Hauptman Reports"), and a vocational assessment and report created by Reliance Standard's paid in-house vocational staff ("the Vocational Report"). Prior to issuing this final denial of plan benefits, Reliance Standard did not inform Glazer, nor her treating doctors, of this new evidence that was generated during the time period of January 2005 through May 2005. In the same correspondence where Glazer was informed for the first time of this new evidence and the revised rationale alleged to deny her benefits, Reliance Standard also informed Glazer that its "claim decision [was] now final; as you have exhausted any administrative remedies available to you" and that she had "the right to bring a civil action under [ERISA]." Glazer was never afforded an opportunity to review and respond to the Hauptman Reports nor the Vocational

Report prior to Reliance Standard closing the administrative record. Accordingly, Glazer's only recourse was to file this lawsuit in federal court.

B. The District Court Proceeding

On January 23, 2006, Glazer filed a civil action pursuant to ERISA against Reliance Standard in the United States District Court for the Southern District of Florida. On September 25, 2006, the District Court entered a summary judgment in favor of Reliance Standard. In so doing, the Court: (1) limited its review to the administrative record that was before Reliance Standard at the time of its final denial; (2) did not address Glazer's request for a remand to Reliance Standard for a reopening of the administrative record to allow her to respond to the new evidence and rationale asserted by Reliance Standard in its final denial; and (3) did not address Glazer's argument that she had been deprived of the "full and fair review" guaranteed her under ERISA.

C. The Eleventh Circuit's Decision

On appeal of the summary judgment, the Eleventh Circuit affirmed the District Court's holding that Reliance Standard's termination of Glazer's benefits was "not wrong." In so holding, the Court expressly ruled that a court's review of an ERISA benefits denial case is limited to the administrative record before an administrator at the time of its final denial, and that it is the plan participant's burden to prove: that she is disabled under the Plan and that the administrator's denial decision was "wrong."

Subject of this Petition is the Eleventh Circuit's holding that a plan administrator is not required to produce appeal-level evidence, which it has generated and considered in upholding a denial of a participant's plan benefits, prior to issuing its final denial to allow the participant the opportunity to review and respond to the new evidence. Specifically, the Eleventh Circuit held that Reliance Standard was only required to provide Glazer with the Hauptman Reports after Reliance Standard had issued its final denial, and thus after the administrative record had closed. The Eleventh Circuit found that to hold otherwise would be contrary to the plain text of the DOL Regulations, because the DOL Regulations only require an administrator to produce all "relevant" documents to a plan participant. The Court held that according to the DOL Regulations, a document is "relevant" only if it "[w]as relied upon" or "[w]as submitted, considered, or generated in the course of making the benefit determination." The Eleventh Circuit held that Reliance Standard had not "relied upon" the Hauptman Reports or "used the report 'in the course of making the benefit determination'" until after its final denial letter had been issued. The Court held that only after Reliance Standard had issued its final denial letter was it required to produce any new evidence it generated or relied upon in rendering a final denial. The Eleventh Circuit relied heavily upon the Tenth Circuit's decision issued in *Metzger v. UNUM Life Insurance Company*, for the proposition that subsection (h)(2)(iii) of the DOL regulations "does not require a plan administrator to provide a claimant with access to the medical opinion reports of appeal-level reviewers prior to a final decision on appeal," and that "requiring these documents to be

produced earlier would create 'an unnecessary cycle of submission, review, re-submission, and re-review.'" The Eleventh Circuit also asserted that according to the DOL, the sole purpose for the "production of these [relevant] documents is to enable a claimant to evaluate whether to appeal an adverse determination," and reasoned that "[d]ocuments produced before a decision is made would not assist a claimant in deciding whether to pursue an appeal because the claimant would not yet know if there had been an adverse determination."

REASONS FOR GRANTING THE PETITION

This Petition should be granted because there are squarely conflicting decisions between the Eighth, Tenth, and Eleventh Circuit Courts of Appeal, which has caused vast confusion to occur within the district courts regarding the issue presented in this case. In significant part, this confusion involves the intent of the DOL in promulgating 29 C.F.R. § 2560.503-1, which was enacted pursuant to 29 U.S.C. § 1133. As the DOL is the entity entrusted with creating regulations to promote Congress' goals in enacting ERISA, confusion among the courts as to the intent behind the DOL regulations and § 1133 of ERISA is especially problematic and can only breed additional conflict within the courts deciding future ERISA benefit denial cases. Furthermore, and similar to many ERISA-governed group disability plans, the Plan at issue in *Glazer* is national in scope[1] and at least two circuit courts have delivered conflicting decisions on this issue directly related to claims administration. Accordingly,

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1. *See https://www.ultirecruit.com/USG1006/JobBoard/listjobs.aspx.*

participants that are covered under the same Plan in the Eighth Circuit are afforded more procedural protections than participants in the Tenth and Eleventh Circuits. In the Eighth Circuit, plan participants are provided with the opportunity to review and respond to all evidence utilized against them prior to the closure of the administrative record. Conversely, plan participants under the same Plan are barred from submitting rebuttal evidence to respond to evidence gathered by the plan administrator during the appeals process in the Tenth and Eleventh Circuits. Moreover, administrators that provide ERISA plans in the Eighth Circuit and also in the Tenth or Eleventh Circuits, like Reliance Standard, are forced to modify their claims procedures according to which circuit court has jurisdiction, despite the same federal statute and regulations governing all ERISA benefit claims. This is especially problematic given the conflict among the district courts on this issue. Not only must nationwide plan administrators utilize conflicting standards of plan administration according to which circuit court has jurisdiction over a claim, but because many circuits currently have not directly addressed this precise issue, plan administrators must attempt to modify their claims procedures according to which district within the silent circuits that the claim arises in. This directly conflicts with ERISA's mandate for uniformity in plan administration. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384-385 (2002). In enacting ERISA, Congress intended:

> [T]o ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and

> financial burden of complying with conflict directives . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656-657 (1995) (citations omitted). Uniformity cannot be accomplished if plan administrators are subject to different legal obligations and plan participants are subjected to conflicting plan administration standards in different jurisdictions. *See Engelhoff v. Engelhoff*, 532 U.S. 141, 148 (2001).

Moreover, the issue before this Honorable Court extends far beyond the deprivation of one plan participant's right to procedural due process in ERISA cases. According to the March 2007 Current Population Series, 137.1 million people were covered by private-sector employer-sponsored health insurance plans in 2006.[2] Millions of participants and beneficiaries in the United States rely upon their employee benefits for insurance coverage that they wish they never had to use.[3] As such, whether plan participants are afforded an opportunity to review and respond to evidence used against them by plan administrators, has far reaching

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2. *See* U.S. Dept. of Comm., Bureau of the Census, Current Population Survey (March 2007). The Employee Benefits Security Administration does not generate estimates of disability insurance plans separately.

3. U.S. Dept. of Labor, Employee Benefits Security Admin.: Filing a Claim for Your Health and Disability Benefits, 1 (Sept. 2006).

implications affecting a significant section of the population. Given the considerable number of plan participants and potential ERISA benefit claims, preserving Congress' goal of uniform claims handling practices is imperative. Not only is this goal of ERISA frustrated when the circuit courts are in conflict about an administrator's obligation to disclose documentation at the administrative level, but so is another chief goal of ERISA – the promotion of administrative resolution of claims. This matter is of great public importance, warranting this Honorable Court's review, and this case provides an ideal vehicle for resolution.

I. This Petition Should Be Granted To Resolve Squarely Conflicting Decisions Between The Eighth, Tenth, And Eleventh Circuits, To Prevent A Worsening Divide Among The Circuits, And To Resolve Confusion Among The District Courts.

A. There Is Square Conflict Among The Eighth, Tenth, And Eleventh Circuits, And Additional Conflicting Decisions Among The Remaining Circuits.

There is a clear split among the Eighth, Tenth, and Eleventh Circuits on the precise factual and legal issue presented in this case, which only this Court can resolve. The Eighth Circuit holds that for an ERISA plan administrator to provide a participant with a full and fair review guaranteed her under 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1 (2000), it must permit a participant to review and respond to evidence developed by the administrator during the appeals process, prior to the final benefit decision being issued. *Abram v.*

Cargill, Inc., 395 F.3d 882 (8th Cir. 2005). The *Abram* Court held:

> The process used by the Plan was not consistent with a full and fair review. Abram was not provided access to the second report by Dr. Gedan that served as the basis for the Plan's denial of benefits until after the Plan's decision. Without knowing what "inconsistencies" the Plan was attempting to resolve or having access to the report the Plan relied on, Abram could not meaningfully participate in the appeals process . . . . This type of "gamesmanship" is inconsistent with full and fair review. There can hardly be a meaningful dialogue between the claimant and the Plan administrators if evidence is revealed only after a final decision. A claimant is caught off guard when new information used by the appeals committee emerges only with the final denial. Abram should have been permitted to review and respond to the report by Dr. Gedan.

Id. at 886 (citations omitted). Relying upon the Third Circuit's seminal opinion in *Grossmuller*, the *Abram* Court explained: "'[T]he persistent core requirements' of full and fair review include 'knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision.'" *Id.* (*quoting Grossmuller v. Int'l Union, UAW*, 715 F.2d 853, 858 n.5 (3d Cir.1983)).

The Tenth Circuit's position on this issue, however, is entirely contrary to that of the Eighth Circuit. In *Metzger v. Unum Life Insurance Company of America*, the Tenth Circuit held:

> In light of the sum of procedural requirements of 29 C.F.R. § 2560.503-1 and the Department's explanation of those regulations, we hold that subsection (h)(2)(iii) does not require a plan administrator to provide a claimant with access to the medical opinion reports of appeal-level reviewers prior to a final decision on appeal. Instead, the regulations mandate provision of relevant documents, including medical opinion reports, at two discrete stages of the administrative process. First, relevant documents generated or relied upon during the initial claims determination must be disclosed prior to or at the outset of an administrative appeal. 29 C.F.R. § 2560.503-1(h)(2)(iii). Second, relevant documents generated during the administrative appeal – along with the claimant's file from the initial determination – must be disclosed after a final decision on appeal. 29 C.F.R. § 2560.503-1(i)(5).

476 F.3d 1161, 1167 (10th Cir. 2007). The Tenth Circuit reasoned that allowing ERISA participants to review and respond to evidence gathered by the administrator during the appeal review stage would prolong the appeals process by creating an "unnecessary cycle of submission, review, re-submission, and re-review." *See id.* at 1166-67. The Tenth Circuit's holding in *Metzger* has engendered the Eleventh Circuit's decision

in *Glazer*, which now both stand in direct conflict with the Eighth Circuit's holding in *Abram*. This Court should grant this Petition to resolve this square conflict among the Eighth, Tenth, and Eleventh Circuits.

Furthermore, while the remaining Circuits have not expressly addressed *Abram* and *Metzger*, they have ruled in cases where the critical issue in the case at bar – whether a participant is deprived of a meaningful review of her ERISA claim when the administrator does not provide her the opportunity to review and respond to certain evidence – was implicated. Since 1983, the Third Circuit has relied upon its seminal opinion in *Grossmuller*, for guidance. 715 F.2d 853. In *Grossmuller*, the Third Circuit held that the ERISA plan administrator failed to provide Grossmuller with a "full and fair" review when it did not allow him the opportunity to examine or address the evidence used against him to terminate his disability benefits. The Court reasoned that a review of "the administrative law context" reveals that: "the persistent core requirements of review intended to be full and fair include knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." *Id.* at 858, n.5 (*citing Morgan v. United States*, 304 U.S. 1, 18-19, (1938)). The Third Circuit's reasoning and position in *Grossmuller* sharply contrasts with the reasoning found in *Metzger* and *Glazer*.

While *Grossmuller* is oft referred to by the other Circuits as setting forth the "most widely accepted criteria for determining what constitutes a full and fair review" under ERISA,[4] and while the Circuits have expressed approval of the *Grossmuller* test, there is a clear variation amongst the Circuits in determining the circumstances under which a participant must be provided with an ability to review and respond to evidence gathered by an administrator which is ultimately used to support a denial of an ERISA benefits claim. *Compare, e.g., Houston v. Unum Life Ins. Co. of Am.*, 246 Fed. Appx. 293 (6th Cir. 2007) (unpublished) (emphasis in original) (holding that where the administrator failed to provide its participant the opportunity to review and respond to its "revised rationale for terminating her benefits, including [the non-treating, non-examining appeal-level physician's report]," the participant was denied a full and fair review because a "[f]ull and fair review does not mean that an insurance company can simply mouth the same reason [for denial, but instead includes]: knowing what evidence the decision-maker relied upon [and] *having an opportunity to address the accuracy and reliability of that evidence*"), *and Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621, 625-26 (7th Cir. 2005) (finding that the ERISA participant was denied a "meaningful review" of the administrator's denial and explaining:

> Ms. Schneider was not provided with the nine and one-half page report which Dr. Spierer

4. *See e.g., Crocco v. Xerox Corp.*, 956 F. Supp. 129, 139 (D. Conn. 1997), *aff'd in pertinent part* 137 F.3d 105, 108, 109 (2d Cir. 1998).

> prepared and on which Sentry insists it based its decision to terminate benefits. . . . [and] [b]ecause Ms. Schneider did not know what reasons motivated Dr. Spierer's conclusion that she was no longer disabled, she could hardly seek review of that conclusion

with Ellis v. Metro. Life Ins. Co., 126 F.3d 228, 237 (4th Cir. 1997) (holding that the initial medical review report used by MetLife to deny Ellis's claim was "the most critical document" for Ellis to be allowed access, but conversely finding that MetLife was not required to provide Ellis with the two subsequent appeal-level medical review reports "as a part of the review procedures" explaining that "the initial decisional process and the subsequent review procedures are distinct," but complicating its holding by finding MetLife neutralized any harm of failing to provide the first medical review report by providing the second medical report to Ellis's health care providers for "critique" and "permitting Ellis and her health care providers to submit additional data in response" prior to MetLife issuing its final denial of the claim). *Also Compare, e.g., Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 974 (2006) (holding that when "an administrator . . . adds, in its final decision, a new reason for denial, a maneuver that has the effect of insulating the rationale from review" it violates both 29 U.S.C. §§ 1133(1) and (2), and the appropriate remedy in this situation is that a participant be entitled to submit evidence at bench trial in the district court to rebut the administrator's new rationale for its final denial), *and Fredrick v. Intel Corp.*, 181 F.3d 1105, 1111 (9th Cir. 1999) (holding the plan participant was entitled to admit

evidence in court but the administrator was not, explaining the claim procedures applied by the administrator prevented the participant from submitting the evidence necessary to support his claim for benefits), *and Miller v. United Welfare Fund*, 72 F.3d 1066, 1074 (2d Cir. 1995) (remanding to the administrator where it failed to provide a full and fair review, where the administrator was to: first, address the evidence presented at the impermissible trial that occurred, and then allow the participant "to produce any additional evidence to rebut any evidence on which the [administrator] could rely to deny benefits" prior to the closure of the administrative record), *with Silver v. Executive Car Leasing Long-Term Disability Plan*, 466 F.3d 727, 732, n.2 (9th Cir.2006) (commenting in a footnote, in holding that a participant was not deprived of a full and fair review when he was not allowed to respond to appeal-level evidence generated by the administrator prior to the final benefit determination, that "in order for [an administrator] to evaluate [a participant's] appeal fairly, it *ha[s]* to wait until [the participant] has submitted all of his materials; for [an administrator] to do otherwise would either undermine [a participant's] ability to present all of his supporting information or lead to an interminable back-and-forth between the plan administrator and the claimant"), *and DiGregorio v. Hartford Comprehensive Employee Benefit Serv. Co.*, 423 F.3d 6 (1st Cir. 2005) (holding that although the administrator failed to provide the claimant with a full claim file and technically failed to comply with the DOL regulations, it still provided her with the primary pieces of evidence relied upon to deny the claim which still allowed the participant to "prepare an informed response to [Hartford's] decision").

However, the Fifth Circuit has taken an approach that is unique to its sister circuits. The Fifth Circuit holds that "the administrative record consists of relevant information made available to the administrator prior to the complainant's filing of a lawsuit [as long as] the administrator [is given] a fair opportunity to consider it," which allows the plan participant (at her option) to respond to evidence used by the administrator to deny her claim, even after a final denial decision has been issued. *Vega v. National Life Ins. Servs.*, 188 F.3d 287, 300 (5th Cir. 1999) (en banc). In its *en banc* opinion, the Fifth Circuit acknowledged that in denying a plan participant the ability to supplement the administrative record at trial, "there is a concern that a self-interested administrator can manipulate this process unfairly (e.g., by permitting the administrator to exclude from the record information that would weigh in favor of granting the claim) . . . ." *Id.* The Court explained that its motivating concern was to resolve claims at the administrative level. *See id.* While the Fifth Circuit has developed this safeguard designed to prevent the unfair manipulation of process by the administrator, the Court has still been forced to decide issues regarding an administrator's failure to disclose certain information that forecloses a participant's ability to adequately participate in a meaningful administrative review of her claim. *See, e.g., Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 394 (5th Cir. 2006) (holding a plan administrator's failure to identify vocational experts consulted in connection with a claim denial deprives a participant of a full and fair review because "the two subsections of section 1133 [are meant to] complement[] each other" and "the requirement that the administrator disclose the basis for its decision is

necessary so that beneficiaries can adequately prepare for any further administrative review . . . [and to] help ensure the 'meaningful review' contemplated by subsection (2)").

These additional conflicting decisions of the remaining circuits, combined with the published decisions of *Abram* and *Metzger*, have caused confusion among the district courts. The split and lack of uniformity among the Circuits on the issue presented in this case is in imminent danger of expanding, and this Honorable Court should grant this Petition to prevent a worsening divide among the Circuits.

B. There Is Confusion Among The District Courts.

Given the split and lack of uniformity among the Circuits, the district courts have been grappling to determine which side of the divide their Circuit will eventually land on. This has created vastly different results on the very same issue within the district courts and even between district courts within the same federal circuit. Such an example exists within the Second Circuit. In *Mead v. ReliaStar Life Insurance Company*, the District Court of Vermont held that that the administrator denied the participant a full and fair review when it failed to provide the participant with an opportunity to review and respond to an appeal-level medical report used against the participant in the final denial. No. 2:05-332, 2008 WL 850678, at *9 (D. Vt. Jan. 29, 2008). The court reasoned that the participant was not able to challenge the credibility of the new medical opinion, despite the rationale in the initial denial and final denial remaining the same. *See id.* The district

court acknowledged the conflict among the Eighth and Tenth Circuits, but adopted the reasoning of *Abram*. *See id.* at *8-9. Also decided in 2008, are two decisions by the Southern District of New York Court which are directly contrary to the decision in *Mead*. In *Laub v. Aetna Life Insurance Company*, the court held that the administrator was not required to provide the participant with appeal-level evidence it gathered prior to rendering its final benefit determination. 549 F. Supp. 2d 571, 576 (S.D. N.Y. 2008). The *Laub* Court noted the reasoning of *Metzger* to hold that requiring administrators to provide participants with evidence it gathers and ultimately utilizes during the appeals process would result in an endless cycle of submission and review. *See id.* at 576, n.3. Then, in *Black v. Pitney Bowes Inc.*, in addressing the participant's argument that he was denied a full and fair review in accordance with the reasoning of *Abram*, the court noted that Tenth Circuit has questioned and rejected the Eighth Circuit's reasoning. No. 05-108, 2008 WL 3992306, at *11 n.7 (S.D. N.Y Aug. 26, 2008). However, the *Black* Court found that "even if Dr. Broder's report was disregarded," the administrator's decision to deny the claim was not arbitrary and capricious. *See id.*

However, the confusion among the district courts extends far beyond just the Second Circuit. *See, e.g., Balmert v. Reliance Standard Life Ins. Co.*, No. 2:07-95, 2008 WL 4404299, at *9, n.2 (S.D. Ohio Sept. 23, 2008) (adopting the reasoning in *Metzger* to hold that the participant was not denied a full and fair review when she was not permitted to review and respond to an independent medical examination report solicited by the administrator during the appeals process, and also

rejecting *Abram* for the same reasons as *Metzger*); *Winz-Byone v. Metropolitan Life Ins. Co.*, No. 07-238, 2008 WL 962867 (C.D. Cal. Mar. 26, 2008) (adopting the reasoning in *Metzger*, after acknowledging the conflict among the Eighth and Tenth Circuits on the issue in the case at bar); *Skipp v. Hartford Life Ins. Co.*, No. 06-2199, 2008 WL 346107 (D. Md. Feb. 6, 2008) (acknowledging the conflict between the Eighth and Tenth Circuits but adopting the reasoning in *Metzger* to hold that under the DOL regulations as administrator is not required to produce a medical records review it solicited during the appeals process until after the final benefit determination); *Boldt v. Dow Chemical Co. Voluntary Group Acc. Ins. Plan*, No. 6:06-25, 2007 WL 2329873 (S.D. Tex. Aug. 15, 2007) (recognizing the split among the Eighth and Tenth Circuits, and agreeing with the *Abram* Court's determination that a full and fair review "entitled [a participant] to know what evidence was relied upon by the administrator and respond to that evidence," but declining to adopt the "hard and fast" rule set forth in either *Abram* or *Metzger* without further guidance from the Fifth Circuit).

The district courts within the Eighth Circuit have found the Tenth Circuit's assertion that the *Abram* decision was founded on the pre-2000 amendment regulations invalid. In *Lammers v. American Express Long Term Disability Benefit Plan*, the court was not persuaded by the Tenth Circuit's reasoning in *Metzger*, because the *Abram* decision "was rooted in ERISA's fundamental 'full and fair review' requirement, 29 U.S.C. § 1133(2)." No. 06-1099, 2007 WL 2247594, at *5-6 (D. Minn. Aug. 2, 2007). The *Lammers* Court applied its circuit's precedent in *Abram* to find that the

participant was denied a full and fair review when the administrator failed to allow the participant to review and respond to the two appeal-level medical reports. *See id.* at 6; *see also, Walters v. Prudential Ins. Co. of America*, No. 06-20, 2007 WL 4531311, *18 (N.D. Iowa Dec. 18, 2007). Similarly, the district courts within the Tenth Circuit have followed the holding in *Metzger* when presented with this issue. *See, e.g., Navarro v. Eaton Corp.*, No. 06-1190, 2007 WL 2011205, at *4 (D. Kan. July 9, 2007); *Lunt v. Metropolitan Life Ins. Co.*, No. 2:05-784, 2007 WL 1964514, at *9 (D. Utah July 2, 2007).

However, there is no stronger illustration of the danger for increasing conflict among the circuits on this issue than what occurred in the Eleventh Circuit. Prior to *Metzger*, when faced with the issue presented in the case at bar, several district courts within the Eleventh Circuit expressed approval for the reasoning in *Abram*. *See, e.g., White v. Reliance Standard Life Ins. Co.*, No. 1:05-2149, 2007 WL 187939 (N.D. Ga. Jan. 22, 2007) (adopting the reasoning in *Abram*); *Harris v. Aetna Life Ins. Co.*, 379 F. Supp. 2d 1366 (N.D. Ga. 2005) (adopting the reasoning in *Abram*); *Hamall-Desai v. Fortis Benefits Ins. Co.*, 370 F. Supp. 2d 1283, 1313-15 (N.D. Ga. 2004), *aff'd*, 164 Fed. Appx. 963 (11th Cir. 2006), *rehearing denied*, 179 Fed. Appx. 687 (11th Cir. 2006) (holding that "Fortis' refusal to provide the [appeal-level] reports . . . denied Desai access to information relevant to her claim after the initial denial, 'thus denying [her] the opportunity to respond to this evidence before the decision on review was reached'" and *citing Russo v. Hartford Life & Acc. Co.*, No. Civ. 00-938, 2002 WL 32138296 (S.D. Cal. Feb. 5, 2002) (holding, after the benefit of the Secretary of Labor's briefing, that

"[d]enying a claimant access to information that is generated after an initial denial, but is subsequently relied upon by the administrator in reviewing the claim on appeal, effectively denies the claimant with a full and fair review," and that "[b]y requiring . . . administrators to maintain . . . procedures that allow claimants access to . . . documents . . . is consistent with both plain language of the regulation, as well as the spirit and intent of ERISA . . . . regardless of whether it was generated prior to or after an initial benefit denial")). Following *Metzger*, this did not change. *See, e.g., Smith v. Continental Cas. Co.*, No. 1:06-1441, 2007 WL 2071538 (N.D. Ga. July 16, 2007) (adopting the Eighth Circuit's reasoning in *Abram* in holding that the claimant was denied a full and fair review by the administrator when denied the opportunity to review and respond to an appeal-level medical summary which was utilized to support the final benefit denial). Eventually, the matter reached the Eleventh Circuit in *Glazer* and the Circuit Court was forced to make a decision between the contrasting decisions, increasing the already existing conflict within the circuit courts.

Given the clear split among the Eighth, Tenth, and Eleventh Circuits and the confusion among the district courts on this issue, without resolution from this Honorable Court the conflict within the Circuit Courts will almost certainly increase. Conflict within the circuits on this issue frustrates ERISA's chief goal of uniformity in claims administration. The Eleventh Circuit's reasoning is clear, the relevant facts are well-developed and the issues clearly defined. Accordingly, this case provides an ideal vehicle by which the Court can resolve the circuit conflict.

C. There Is Additional Conflict Among The Circuit And District Courts Regarding The Intent Of ERISA's Full And Fair Review Provisions And The DOL's Accompanying Regulations.

In large part, the conflict among the circuit courts and the confusion among the district courts is due to disagreement about the intent of the DOL in promulgating 29 C.F.R. § 2560.503-1 (2000). Such confusion within the courts is especially problematic in ERISA benefit cases because the DOL is entrusted with creating and enforcing regulations to carry out the purposes of Congress in enacting ERISA.[5] Confusion within the circuits about the requirements under the DOL regulations can only lead to confusion among participants and administrators about the true requirements in the administrative claims process. Resolution of this issue is essential to ensure that the courts properly and consistently interpret the DOL regulations and this case presents an ideal vehicle to resolve the conflict regarding the requirements of 29 C.F.R. § 2560.503-1(2000).

At the core of the *Metzger* Court's criticism of the Eighth Circuit's holding in *Abram*, is its assertion that the Eighth Circuit was applying the pre-2000 amendment regulations, despite the fact that the *Abram* Court specifically cited to 29 C.F.R. § 2560.503-1(h) (2000). *Metzger*, 476 F.3d at 1168, n.3. The Tenth Circuit suggests that the Eighth Circuit therefore did not consider the 2000 regulation's requirement that a healthcare professional review medical evidence, which

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5. *See* 29 U.S.C. § 1133.

the *Metzger* Court asserted would create an endless cycle of review and re-review.[6] *See id.* at 1165, 1168, n.3. The Tenth Circuit further concluded that the DOL's intent in requiring disclosure of documents under its regulations was to provide claimants with the ability to determine whether to seek further appeal, and that disclosure of appeal-level evidence prior to a final denial would not further this purpose. *See id.* at 1166-67 (*citing* ERISA Claims Procedure, 65 Fed. Reg. 70,252 (Nov. 21, 2000)[7]). The Tenth Circuit's reasoning engendered support by the Eleventh Circuit in *Glazer* and the district courts that have specifically sided with the *Metzger* decision and rejected the reasoning of *Abram*. However, the *Abram* decision, which was decided two years after the 2000 amendments to the regulations were enacted, focused on the core requirements of a "full and fair review" under 29 U.S.C. § 1132(2). *Abram*, 395 F.3d at 886. Furthermore, the district courts that have adopted *Abram* and specifically rejected *Metzger*, find

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6. The claim in *Abram* arose in 2000, the year that the amended regulations were enacted. However, the Eighth Circuit decided the claim in 2002, two years after the regulations had been enacted. Accordingly, the Tenth Circuit's assertion that the Eighth Circuit likely did not consider that the new regulations required administrators to seek the advice of healthcare professionals, and thus that it did not contemplate its concern over a prolonged review process, is unlikely.

7. In the section cited to by the Tenth Circuit, the DOL explained that its purpose in promulgating the amendments was to "clarify" the *type* of documents it intended to be disclosed under the 1977 regulations and earlier in the document provided that the intent was to provide plan participants with "fuller and fairer" claims and appeal procedures. *See* ERISA Claim Procedure, 65 Fed. Reg. at 70,252 (emphasis supplied).

the Tenth Circuit's assertions regarding the DOL's intent unpersuasive. This confusion is further fueled by the Secretary of Labor's statements regarding its intent (as it relates to this exact issue), in its *Amicus Curiae* brief filed in 2002 in the Southern District of California District Court. *See* Brief for Plaintiff as Amici Curiae, *Russo v. Hartford Life & Acc. Co.*, No. Civ. 00-938, 2002 WL 32138296 (S.D. Cal. Feb. 5, 2002). The Secretary explained that the regulation does not limit a participant's right to review and respond to evidence gathered by an administrator prior to the initial denial of benefits, but rather includes all documents that a plan administrator relied on in rendering its *final* benefit determination. *See id.* at 9 (emphasis supplied). The Secretary provided that the "purpose of the regulation is to give claimants the right to review evidence used to deny a claim at a time when they have a reasonable opportunity to address it - - without regard to when the plan obtained it." *Id.* at 10 (citation omitted). The Secretary explained:

> The right to submit issues and comments in writing would be meaningless if the claimant did not have access to those documents which formed the basis for the ultimate denial of the claim. The regulation cannot be fairly interpreted to authorize plans to gather new evidence after the initial denial, use the evidence to affirm the denial on appeal, but never give the claimant the opportunity to challenge the evidence upon which the plan ultimately relies . . . . This result is exactly what the regulation was intended to avoid, and it wastes the often limited resources of

> disabled ERISA plan participants, plans, and the courts by fostering litigation rather than administrative claim resolution.

Id. at 11.

The Tenth Circuit's criticism of the *Abram* decision would likely apply to Secretary's stated intention in promulgating 29 C.F.R. § 2560.503-1 in its *Amicus Curiae* brief filed in *Russo*, as the claim in *Russo* was subject to the pre-2000 amendments to the regulations because it was filed prior to 2002. However, the Secretary filed its brief in *Russo* on November 20, 2001, almost two years after the amendments to the regulations were enacted. If the Secretary intended the 2000 amendments to the regulations to alleviate a plan administrator's responsibility to produce and allow participants to respond to evidence gathered during the appeals process, it is highly unlikely that it would have felt compelled to file an amicus brief in late 2001 in a district court case, adamantly advocating that the regulations required participants to be provided with the opportunity to review and respond to evidence gathered during the appeals process. However, given the fact that the DOL has not directly spoken to its intent in a claim applying the 2000 amendments to the regulations, the conflict within the circuit courts and the district courts regarding the intent of the DOL in promulgating 29 C.F.R. § 2560.503-1(h) will most certainly continue. Resolution of this matter is essential to ensure that the courts interpret the regulation consistent with the purpose of the ERISA statute and DOL regulations. This conflict can only be resolved by this Honorable Court and this case presents an ideal vehicle to provide such a resolution.

II. This Honorable Court Should Grant This Petition Because The Eleventh's Circuit's Decision Contravenes The Purpose Of The DOL Regulations And Frustrates The ERISA Administrative Process Intended By Congress And Fostered By The DOL Regulations.

The Eleventh Circuit's decision that Reliance Standard did not deprive Glazer of a full and fair review when she was not afforded the opportunity to review and respond to appeal-level evidence gathered by Reliance Standard that was ultimately used against her to support a final benefit determination, and the similar holding by *Metzger* in the Tenth Circuit, should be reviewed and reversed by this Honorable Court.

First, the Eleventh Circuit's holding that (1) the DOL regulations require the disclosure of "relevant" documents at only two distinct stages: following an initial adverse benefit determination and again following a final adverse benefit determination, and (2) that the sole purpose for the production of documents by the administrator is to enable a claimant to evaluate whether to appeal an adverse determination, is contrary to both the broad and specific purposes of the DOL regulations. *Glazer*, 524 F.3d at 1246. In its opinion, the Eleventh Circuit asserted that according to 29 C.F.R. §2560.503-1(h)(2)(iii), only "relevant" documents are required to be disclosed by an administrator to a participant, and that a document only becomes "relevant" [8] once it "'[w]as

8. As the DOL determined that the word "pertinent" created substantial confusion as to the type of documents that plan administrators must disclose to plan participants, in the (Cont'd)

relied upon'" or '[w]as submitted, considered, or generated in the course of making the benefit determination.'" *Id.* The Eleventh Circuit's reasoning – because the appeal-level medical reports at issue in *Glazer* were not "relied upon" or "used in the course of making the determination" until Reliance Standard had actually made the final adverse benefit determination, disclosure was not required because the documents were not relevant until the final decision was made – is flawed. *Id.* As the Secretary of Labor explained in its *Amicus*

(Cont'd)

2000 amendments to the regulation, the word "pertinent" was replaced with the word "relevant." ERISA Claims Procedure, 65 Fed. Reg. at 70,252. Under the pre-amendment regulations the DOL merely defined "pertinent documents" as "documents relating to the denial." *See* Brief for the Plaintiff at 10, *Russo v. Hartford Life & Acc. Co.*, No. 00-938, 2002 WL 32138296 (S.D. Cal. Feb. 5, 2002) (*citing* Claims Procedure for Employee Benefit Plans, 42 Fed. Reg. 27,426 (May 27, 1977) and explaining, that "pertinent documents" includes "all documents gathered by the plan and relied upon to affirm the initial denial"). However, in an attempt to clarify the type of documents that must be disclosed, the DOL added more encompassing language to the definition of "relevant documents" to include all documents which were "relied upon in making the determination, or was submitted to the plan, considered by the plan, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the determination." ERISA Procedure, 65 F.R. at 70,252. Thus, the 2000 regulations were amended merely to clarify the type of documents that required disclosure, as contemplated by the 1977 regulations, which the DOL subsequently explained must be disclosed "at a time when [plan participants] have a reasonable opportunity to address it." Brief for the Plaintiff at 10, *Russo v. Hartford Life & Acc. Co.*, No. 00-938, 2002 WL 32138296 (S.D. Cal. Feb. 5, 2002).

Curiae brief filed in *Russo*, "the language of the claims regulation does not limit a plan's duty to disclose 'pertinent[9] documents' to evidence received or developed by the plan prior to the initial claim denial." Brief for the Plaintiff at 9, *Russo v. Hartford Life & Acc. Co.*, No. Civ. 00-938, 2002 WL 32138296 (S.D. Cal. Feb. 5, 2002). Instead, the Secretary explained, the right to review and respond "applies to all documents gathered by the plan and relied upon to affirm the initial denial." *Id.* at 9-10.

The Eleventh Circuit's contention that according to the DOL the sole purpose for the "production of these documents is to enable a claimant to evaluate whether to appeal an adverse determination," and holding that "[d]ocuments produced before a decision is made would not assist a claimant in deciding whether to pursue an appeal because the claimant would not yet know if there had been an adverse determination," places constraints on the disclosure of documents that are simply not found in the DOL regulations. *Glazer*, 524 F.3d at 1246. While 29 C.F.R. § 2560.503-1 sets *minimum* requirements in the disclosure of relevant documents, nothing in the regulation limits disclosure of evidence gathered by the administrator during the administrative appeals process prior to the final benefit determination. Furthermore, according to the Secretary, the "purpose of the regulation is to give claimants the right to review evidence used to deny a claim at a time when they have a reasonable opportunity to address it — without regard to when the plan obtained it." Brief for the Plaintiff at 10, *Russo v. Hartford Life & Acc. Co.*, No. Civ. 00-938,

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9. *See supra* note 9.

2002 WL 32138296 (S.D. Cal. Feb. 5, 2002) (citation omitted). The Secretary has explained:

> The right to submit issues and comments in writing would be meaningless if the claimant did not have access to those documents which formed the basis for the ultimate denial of the claim. The regulation cannot be fairly interpreted to authorize plans to gather new evidence after the initial denial, use the evidence to affirm the denial on appeal, but never give the claimant the opportunity to challenge the evidence upon which the plan ultimately relies . . . .

Id. at 11.

Second, the effect of the incorrect decision by the Eleventh Circuit in *Glazer* has far reaching implications that affect the procedural due process rights of ERISA participants which are at the heart of the ERISA administrative process. The Eleventh Circuit's decision is this: at no stage in the administrative or litigation process is an ERISA participant like Glazer permitted to test the credibility of an administrator's appeal-level physician's opinions, proffer evidence to rebut his conclusions, or properly prepare and present her claim prior to the closure of the administrative record. The Eleventh Circuit's decision has the effect of allowing plan administrators to solicit and place evidence into the administrative record, which it ultimately uses against a plan participant, while forever barring participants from bringing forth rebuttal evidence at the administrative level or before the court in litigation.

Essentially, plan administrators are being enabled to insulate the evidence it uses against plan participants from any meaningful challenge, forcing the reviewing court to render a decision on the administrator's ultimate determination without being privy to the participant's response, and while shrouding the administrator's decision in deference. Not only does this deny participants procedural due process rights in satisfying their burden of proof in their ERISA benefit claim,[10] but it is simply contrary to the foundation of a "full and fair review" under ERISA that requires "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." Brief for the Plaintiff at 12, *Russo v. Hartford Life & Acc. Co.*, No. Civ. 00-938, 2002 WL 32138296 (S.D. Cal. Feb. 5, 2002) (citing *Grossmuller*, 715 F.2d at n.5).

This holding, which has the effect of depriving a participant of procedural due process, disturbs the balance required to allow the ERISA administrative framework to carry out the purpose intended by the DOL, Congress, and the circuit courts. ERISA and the

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10. It is uniformly held that it is an ERISA participant's burden to prove entitlement to benefits, which the Eleventh Circuit also required in *Glazer*. 524 F.3d at 1247. This could entail proving that one is "disabled" under the plan terms and entitled to disability benefits, or proving that a procedure was "medically necessary" and as such covered by a health insurance plan, or the like depending upon the type of plan benefit, despite the administrator proffering contrary evidence to deny the benefit claim.

respective DOL regulations were created to foster a comprehensive and fair administrative system for the efficient resolution of ERISA benefit claims.[11] Inherent in this process are the concepts of exhaustion of administrative remedies and a deferential standard of judicial review. The exhaustion requirement promotes the administrative resolution of claims and alternatively assists the courts in resolving ERISA benefit controversies by presenting to the court fully considered decisions, in which it can afford deference to the administrator's decision. However, only if crucial procedural rights are afforded a participant, is the

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11. *See Grossmuller*, 715 F.2d at 857, explaining:

> The House conference report accompanying the act directed courts to regard ERISA civil actions brought by participants and beneficiaries 'as rising under the laws of the United States in similar fashion to those brought under § 301 of the Labor Management Relations Act of 1947.' H.R. Rep. No. 93-807, 93d (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 5107. Within the labor context federal courts have consistently favored internal resolution procedures in order to promote orderly settlement of disputes, to assure uniform processing and treatment of claims, and to avert whenever possible the expense and delay incident to resort to the courts. *See generally Hines v. Anchor Motor Freight, Inc.*, 424 U.S. 554, (1976), and *Vaca v. Sipes*, 386 U.S. 171 (1967). *See also*, 29 U.S.C. § 173(d). ERISA also endorsed this policy by conferring broad managerial discretion upon the pension plan trustees, who are primarily responsible for devising and implementing claims procedures.

(citations omitted).

administrator deserving of the deference granted it by the courts. As the Secretary of Labor explained in its *Amicus Curiae* brief filed in *Russo*:

> The claims regulations must be construed in a manner that protects claimants, plans, and the courts. For claimants, knowledge of the evidentiary basis for the decision ensures that they have a reasonable opportunity to understand the evidence on which the decision will be based and to supplement that evidence if appropriate without resorting to litigation . . . . For plans and the courts, the claimant's opportunity to review and address evidence used to deny the claim ensures that the final decision is based upon a complete and accurate record — the underlying premise that supports both the deferential standard of review and the exhaustion of administrative remedies requirements.

Brief for the Plaintiff at 16, *Russo v. Hartford Life & Acc. Co.*, No. Civ. 00-938, 2002 WL 32138296 (S.D. Cal. Feb. 5, 2002) (citations omitted).

Furthermore, an interpretation of the DOL regulations that requires plan administrators to provide participants with an opportunity to review and respond to appeal-level evidence, ultimately utilized against the participant, prior to the final benefit determination, is consistent with the requirement that an ERISA participant exhaust her administrative remedies. Brief for the Plaintiff at 14, *Russo v. Hartford Life & Acc. Co.*, No. Civ. 00-938, 2002 WL 32138296 (S.D. Cal. Feb.

5, 2002). This requirement is frustrated if plan participants are unable to discover the evidentiary basis for the administrator's decision until their only option is a lawsuit. Moreover, it contravenes one of the chief goals of ERISA, which is to promote the administrative resolution of ERISA benefit claims.[12] Still further, the deferential review standard applied in most ERISA cases[13] renders the protections provided by the regulations even more significant. In most cases, the administrative review process is the plan participant's only opportunity to present her claim, to correct errors made by the administrator in reviewing the claim, and to supplement the administrative record prior to judicial review. Under these constraints, an administrator depriving a plan participant of the right to review and respond to evidence used against her and then hiding behind the cloak of deference is certainly not in concert with the concept of a full and fair review or the protections afforded participants under ERISA. Furthermore, the rule of *Glazer* and *Metzger* creates the incentive for conflicted administrators to refuse to engage in a meaningful dialogue with the claimant during the initial claim phase, refrain from fully investigating initial claims, and to gather and submit evidence into the administrative record only after an appeal is submitted, when the claimant is foreclosed

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12. *See supra* note 11.

13. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989), (holding that the default standard of review is *de novo* unless "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," then an arbitrary and capricious standard of review applies).

from ever responding to the previously undisclosed information. As the Secretary of Labor provided in its *Amicus Curiae* brief filed in *Russo*, "an interpretation of the regulation that allows plans to withhold evidence used to justify a claim denial undermines the rationale for limiting the court's review of evidence to what was before the plan." Brief for the Plaintiff at 15, *Russo v. Hartford Life & Acc. Co.*, No. Civ. 00-938, 2002 WL 32138296 (S.D. Cal. Feb. 5, 2002).

Allowing plan participants an opportunity to review and respond to evidence gathered by the administrator prior to the final benefit determination ensures that participants receive the fullness and fairness of review contemplated by 29 U.S.C. § 1133 and its accompanying DOL regulations. It also ensures that that chief goals of ERISA, including the promotion of administrative resolution of claims and that any adverse claim determinations are based on a complete administrative record, are furthered. The issue before this Honorable Court has far reaching implications for a substantial portion of the population and promotes non-uniform claims administration under ERISA. Resolution of this matter is imperative to prevent frustration of the ERISA administrative process intended by Congress and the DOL.

CONCLUSION

For the foregoing reasons, petitioner respectfully requests the Court to grant the petition for a writ for certiorari in this case.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED APRIL 21, 2008

UNITED STATES COURT OF APPEALS ELEVENTH CIRCUIT

No. 06-15855

PRISCILLA GLAZER,

Plaintiff-Appellant,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY, a Pennsylvania Corporation,

Defendant-Appellee.

April 21, 2008

Appeal from the United States District Court for the Southern District of Florida.

Before BIRCH, PRYOR and KRAVITCH, Circuit Judges.

PRYOR, Circuit Judge:

This appeal raises an issue of first impression in this Circuit under the Employee Retirement Income Security Act of 1974: when medical reports relied on by

a plan administrator during the review of a denial of benefits must be produced to the claimant for her to receive a "full and fair review." 29 U.S.C. § 1133(2). Priscilla Glazer appeals a summary judgment against her complaint about the denial of her application for long term disability benefits by Reliance Standard Life Insurance Company. *Id.* § 1132(a)(1)(B). Glazer argues that Reliance failed to provide her with a "full and fair review" of its initial decision to deny her application for benefits, the district court applied an incorrect standard of review, and Reliance wrongly denied her benefits. We reject Glazer's argument that Reliance denied her a "full and fair review"; the pertinent federal regulations did not require Reliance to produce the medical reports requested by Glazer during the pendency of the review. We also conclude that the district court applied the correct standard of review and the decision of Reliance to deny Glazer's application for benefits was right. We affirm.

I. BACKGROUND

For several years, Glazer was employed as a senior technical writer for The Ultimate Software Group, which offered employees insurance for long-term disability with a plan provided by Reliance. The plan granted Reliance discretion "to determine eligibility for benefits." The plan also provided that an insured is "totally disabled" if the insured "cannot perform the substantial and material duties of his/her regular occupation." Glazer began to experience pain in her shoulders in 1996 and has since been diagnosed with several conditions,

including *myofascial pain syndrome*, *fibromyalgia*, *cervical spondylosis*, chronic *cervical strain*, and *radiculopathy*.

In June 2003, Glazer stopped working based on the recommendation of her physician, Dr. Thomas Hoffeld, and Glazer applied for disability benefits under the plan. During the fall of 2003, Hoffeld found that Glazer had difficulty typing and that she could sit only 33 percent of the time.

On January 13, 2004, Reliance approved Glazer's application. In April 2004, Hoffeld opined that he did "not see [Glazer] returning" to work. Dr. Alan Novick began treating Glazer in October 2003 and noted improvement of her pain in May 2004.

In March 2004, Reliance requested updated medical records from Glazer's physicians. Hoffeld did not respond to the request. On May 7, 2004, Novick represented on a form provided by Reliance that Glazer could sit continuously; perform basic physical activities, including simple grasping and fine manipulation; and work at a sedentary level. Based on an interview of Glazer, Novick's representations, and job descriptions of Glazer's occupation, Reliance concluded that Glazer was able to perform the requirements of her job.

In July 2004, Reliance terminated Glazer's long-term disability benefits. Glazer visited Dr. Benjamin Lechner, whom she had not seen since February 2003. Glazer submitted to Reliance a report prepared by

Lechner in which he reviewed her medical conditions, noted she could not use a computer, and opined that Glazer was "disabled for gainful employment due to this condition." Glazer also requested that Reliance review its benefits determination.

Glazer saw Novick in July 2004, and Novick reported that Glazer was feeling better and had remained stable. Novick saw Glazer once in November 2004, twice in February 2005, and once in March 2005. During these examinations, Glazer complained of increased pain, but Novick's description of her condition remained consistent.

As part of the review of its decision to terminate Glazer's benefits, Reliance submitted Glazer's medical records to Dr. William Hauptman for an independent peer review. After reviewing Glazer's records, Hauptman concluded that Novick's evaluation of Glazer's capabilities in May 2004 was consistent with her medical records. Hauptman reasoned that the improvements in Glazer's physical capabilities after Hoffeld's evaluation in 2003 were the result of Novick's treatment. Hauptman also concluded that there was no medical evidence to support Glazer's complaints of increased pain.

After its review, Reliance denied Glazer's application for long term disability benefits. Glazer filed this action in the district court. The district court granted summary judgment in favor of Reliance.

II. STANDARD OF REVIEW

We review a summary judgment *de novo*. *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1134 (11th Cir.2004).

III. DISCUSSION

We evaluate Glazer's arguments in three parts. First, we consider whether Reliance denied Glazer a "full and fair review." Second, we consider whether the district court applied the correct legal standard. Third, we consider whether the decision of the plan administrator was "wrong."

A. To Provide Glazer a "Full and Fair Review," Reliance Was Not Required to Produce Hauptman's Report Earlier.

Glazer argues that she was not provided a "full and fair review" of the denial of her request for benefits as required by ERISA. 29 U.S.C. § 1133(2). If benefits are denied, section 1133 requires the plan administrator, "[i]n accordance with regulations of the Secretary," to provide a "full and fair review . . . of the decision denying the claim." *Id.* § 1133. The administrator must "[p]rovide . . . upon request . . . all documents, records, and other information relevant to the claimant's claim for benefits" for the review to qualify as a "full and fair review." 29 C.F.R. § 2560.503-1(h)(2)(iii). The plan administrator must also "take[ ] into account all comments, documents, records, and other information submitted by the claimant relating to the claim." *Id.* § 2560.503-1(h)(2)(iv).

Glazer argues that the failure of Reliance to provide her with a copy of the report produced by Hauptman during the pendency of the review of the initial denial of benefits deprived her of a "full and fair review." Reliance responds that it was not required to produce the documents it relied upon while it reviewed the initial denial of benefits; the production occurs after a final decision is reached. We agree with Reliance.

Glazer's argument is contrary to the plain text of the regulations. Subsection (h)(2)(iii) requires the plan administrator to produce all "relevant" documents. A document is relevant if it "[w]as relied upon" or "[w]as submitted, considered, or generated in the course of making the benefit determination." *Id.* § 2560.503-1(m)(8)(i)-(ii). Reliance had not "relied upon" the Hauptman report or used the report "in the course of making the benefit determination" until the determination had been made. After Reliance reached its final decision, all relevant documents generated during the review and initial claim determination had to be produced to the claimant. *Id.* § 2560.503-1(i)(5). This requirement would be superfluous if the claimant had a right to the documents during the pendency of the review. *See Kornblau v. Dade County*, 86 F.3d 193, 195 (11th Cir.1996) (courts should avoid rendering other provisions of a regulation superfluous or inoperative).

The only other circuit court that has decided this issue reached the same conclusion as we do. The Tenth Circuit held, in *Metzger v. UNUM Life Insurance Company of America*, that "subsection (h)(2)(iii) does

not require a plan administrator to provide a claimant with access to the medical opinion reports of appeal-level reviewers prior to a final decision on appeal." 476 F.3d 1161, 1167 (10th Cir.2007). The court explained that requiring these documents to be produced earlier would create "an unnecessary cycle of submission, review, re-submission, and re-review." *Id.* at 1166. The court agreed with the Department of Labor that the purpose of the production of these documents is to enable a claimant to evaluate whether to appeal an adverse determination. *Id.* at 1167 (quoting ERISA Claim Procedure, 65 Fed.Reg. 70,246, 70,252 (Nov. 21, 2000)). Documents produced before a decision is made would not assist a claimant in deciding whether to pursue an appeal because the claimant would not yet know if there has been an adverse determination. *Id.*

B. The District Court Applied the Correct Legal Standard.

Glazer argues that the district court erred when it granted summary judgment because there were factual disputes about whether Glazer was disabled, but this argument misunderstands our standard of review. Our review of a denial of benefits is for whether the decision of the administrator was arbitrary and capricious. *Jett v. Blue Cross & Blue Shield of Ala.*, 890 F.2d 1137, 1139 (11th Cir.1989). "When conducting a review of an ERISA benefits denial under an arbitrary and capricious standard (sometimes used interchangeably with an abuse of discretion standard), the function of the court is to determine whether there was a reasonable basis

for the decision, based upon the facts as known to the administrator at the time the decision was made." *Id.* "[W]e review both the administrator's construction of the plan and concomitant factual findings." *See Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1451 (11th Cir.1997).

This Court has created "a well-defined series of steps in reviewing a denial of benefits decision in an ERISA case" to determine whether the decision of the administrator was arbitrary and capricious. *Tippitt v. Reliance Standard Life Ins. Co.*, 457 F.3d 1227, 1231-32 (11th Cir.2006). "At each step, the court makes a determination that results in either the progression to the next step or the end of the inquiry." *Id.* at 1232 (quoting *HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993 (11th Cir.2001)) (internal quotation marks omitted). First, the court "examin[es] the plan documents to determine whether they grant the administrator discretion" in making benefit determinations. *Id.* If the administrator has discretion under the plan, "then at a minimum, the court applies arbitrary and capricious review and possibly heightened arbitrary and capricious review." *Id.* (quoting *HCA*, 240 F.3d at 993) (internal quotation mark omitted). Under either form of review, the court is limited to "the facts as known to the administrator at the time the decision was made." *Jett*, 890 F.2d at 1139.

"[R]egardless of whether the arbitrary and capricious review or the heightened form of that standard of review applies," the court reviews the

decision by the administrator to determine whether it was "wrong." *Tippitt*, 457 F.3d at 1232; *see also Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir.2001) (quoting *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566 n. 12 (11th Cir.1990)). A decision is "wrong" if, after a review of the decision of the administrator from a *de novo* perspective, "the court disagrees with the administrator's decision." *Williams*, 373 F.3d at 1138 & n. 8. The court must consider, based on the record before the administrator at the time its decision was made, whether the court would reach the same decision as the administrator. If the court determines that the plan administrator was right, the analysis ends and the decision is affirmed. *Tippitt*, 457 F.3d at 1232.

Glazer's argument that the district court applied the wrong standard fails. Although there was a dispute about whether Glazer was disabled, there was no dispute about what was in the record when Reliance made its decision. The district court had to review that record and decide whether the resolution of the dispute by Reliance was wrong. The district court reviewed the record and determined that the decision by Reliance was right, which ended the analysis of whether the decision of Reliance was arbitrary and capricious. *Id.* The district court applied the correct standard of review.

Appendix A

C. The Decision by Reliance to Deny Benefits Was Right.

Glazer also contends that the record establishes that she is entitled to disability benefits. To evaluate that argument, we consider, as the district court did, whether the decision of Reliance was "wrong." *Id.* We are limited to the record that was before Reliance when it made its decision. *Jett*, 890 F.2d at 1139. Glazer bears the burden to prove that she is disabled. *Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir.1998).

The denial of Glazer's application for benefits by Reliance was not wrong. Glazer failed to establish that she is disabled. Glazer asserts that the record "clearly demonstrated" that she is disabled under the plan, but she fails to explain how her condition prevents her from performing the "substantial and material" duties of her occupation.

The only support in the record for Glazer's position is Hoffeld's statement and Lechner's report, but that support is unpersuasive. Hoffeld stated that Glazer was not capable of performing her occupation in April 2004, but his opinion was formed before Novick's treatment led to an improvement in Glazer's condition in May 2004. Hoffeld also failed to respond to the request from Reliance for updated medical records. Lechner opined that Glazer was "disabled" in July 2004, but Lechner, who had not seen Glazer in over one year, expressed an opinion that was contrary to both the contemporaneous

observations of Novick and the independent peer review by Hauptman. Neither Hoffeld nor Lechner compared Glazer's physical capabilities with the requirements of her occupation.

The record contains ample evidence that Glazer is not disabled within the meaning of the policy. Her physician, Novick, reported that she was capable of sitting for an eight-hour day, frequent walking, standing, climbing stairs, and simple grasping with her hands. Reliance compared this information about her physical capabilities with a description of her job and determined that she was capable of performing her job requirements. Reliance also relied on the opinion of its reviewing doctor, Hauptman, who reviewed Glazer's medical records and stated that the record supported Novick's findings and that she was capable of working.

We agree with the district court that Glazer failed to establish that she was totally disabled. Because we conclude that Reliance was right, our analysis of the denial of Glazer's application ends. The district court was correct to enter summary judgment in favor of Reliance.

IV. CONCLUSION

We AFFIRM the summary judgment in favor of Reliance Standard Life Insurance Company.

AFFIRMED.

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA DATED AND FILED SEPTEMBER 25, 2006

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 06-60112-CIV-
MIDDLEBROOKS/JOHNSON

PRISCILLA GLAZER,

Plaintiff,

vs.

RELIANCE STANDARD
LIFE INSURANCE COMPANY,

Defendant.

ORDER ON DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

THIS CAUSE comes before the Court on the Defendant's Motion for Summary Judgment (DE 27) filed on July 21, 2006. Plaintiff responded in opposition to Defendant's Motion (DE 29-31). Defendant filed a Reply (DE 32). The Court has reviewed the record, the submissions of counsel, the relevant statutory and case law, and is otherwise fully advised in the premises.

Appendix B

Introduction

The following facts are taken from the submissions of the parties, including Defendant's Motion for Summary Judgment, Plaintiff's Response in Opposition to the Motion to Summary Judgment, the Memorandum of law in support of her Opposition, and Defendant's Reply.

This case involves a claim for long-term disability benefits brought by Plaintiff Priscilla Glazer ("Glazer"), who was a senior technical writer for The Ultimate Software Group. Defendant Reliance Standard Life Insurance Company ("Reliance") insured the long-term disability plan ("Plan") used by The Ultimate Software Group.

Glazer's job entailed writing software documentation, software release notes, computer reports, and communicating via email. As early as 1996, Glazer had pain in her shoulder when using a computer. She continued to work despite this pain and sought medical treatment from her family physician, Dr. Mark H. Lazar. Eventually, in 2003 she reported an increase in pain and began to see other doctors for treatment.

In 2003, Glazer went to see Dr. Thomas A. Hoffeld, specializing in orthopaedics, complaining of increased pain in her shoulders, arms, and hands. At that time, Hoffeld advised her to stay out of work a couple days and then return with no restrictions. She continued to see Hoffeld and to report an increase in her symptoms.

By June 2003, Hoffeld recommended she stop working, at least temporarily to "let things settle down a bit." She continued to have pain in her neck and reported pain from her neck to her left shoulder. Hoffeld reported "limited motion in all parameters of cervical range of motion," but "upper extremities show[ed] good range of motion." Glazer tried using a special pillow and a cervical collar. She continued to have trigger points of pain which she reported were especially present when she used her mouse. During the following couple months, the pain continued. Glazer had diagnoses of arthritis, osteopenia, and myalgia/myositis. She underwent physical therapy, got diagnostic testing, and tried medically to keep her pain under control. By late August, Hoffeld determined Glazer was not a surgical candidate and recommended she see a physiatrist to help her with pain management. Glazer was also seeing Dr. Benjamin Lechner, a rheumatologist, who had diagnosed her with Fibromyalgia and Myofascial pain. He treated her with various medications and recommended home exercise and relaxation techniques to help her with her symptoms.

Glazer continued to stay out of work. In October 2003, Glazer went to see Dr. Alan Novick, a physiatrist, for an evaluation of her chronic neck pain. Novick's treatment included trying various medications to help her with her pain. Novick also recommended home exercise and physical therapy. In April 2004, Novick saw little improvement in her condition and determined trigger point injections were appropriate. Glazer continued on some medication and received the trigger

point injections. In May 2004, after having received the trigger point injections, Novick's notes indicate that Glazer was "doing better with the pain." During that visit, Glazer was advised not to hold her head in one position for a prolonged period of time such as during reading and to take frequent breaks to avoid the tightening of muscles.

In the meantime in 2003, Glazer made her claim for long-term disability under the Plan. The Plan's definition of totally disabled was that "an Insured cannot perform the substantial and material duties of his/her regular occupation." In January 2004, Reliance approved her claim determining that she became disabled on June 13, 2003. In March 2004, Reliance referred Glazer's matter to a rehabilitation service, Paramount, for an evaluation. Paramount interviewed Glazer, who expressed doubt as to whether she could physically resume any type of gainful employment. Glazer continued to have constant cervical pain. She reported that she was able to drive and perform household tasks, including cooking, cleaning, and laundry. As part of its evaluation, Paramount sought updated medical information from Hoffeld and Novick. Only Novick responded. In response to Paramount's request, on May 20, 2004, Novick completed a physical capacities form ("PCQ"). The PCQ asked specific questions about Glazer's physical capabilities. Novick indicated Glazer could sit continuously, stand, walk, and climb stairs frequently, and perform sedentary lifting. In evaluating Glazer's upper extremities, Novick indicated she could frequently perform simple grasping

and fine manipulation and occasionally reach above her mid chest, waist/desk level, and pull/push. Paramount evaluated these limitations with the definition of a writer for technical publications as published in the Dictionary of Occupational Titles published by the Department of Labor ("DOT definition"). The DOT general definition defined her position as a sedentary one which occasionally required lifting, carrying, pushing, and pulling of ten pounds, but was mostly sitting and may involve standing or walking for brief periods of time. Based on Novick's PCQ and the DOT definition, Reliance determined, with Paramount's assistance, that Glazer was able to perform her sedentary level job. Reliance informed Glazer of this by letter in July 2004.

During this time, Glazer continued to see Novick and in July 2004 went to see Lechner again after having not seen him since February 2003. At his July 2004 evaluation of Glazer, Novick reported that she remained stable and functional on her current medication regime so she would continue on that. Lechner, on the other hand, opined in that same month that Glazer was disabled from gainful employment, diagnosing her with cervical spondylosis with nerve root compression. In September 2004, Glazer presented to Novick with new pain and stiffness. Novick prescribed medication and recommended doing blood work to check for additional causes of her pain.

Glazer appealed Reliance's decision. During the appeal, Reliance attempted to have an independent medical examination ("IME") of Glazer completed. However, the IME was not completed. Glazer went to the examination with her lawyer and a court reporter. The doctor conducting the IME informed them that they could not all fit in the examining room. The doctor offered to participate in a deposition after the examination was completed, but Glazer did not accept that offer. Instead she did not go through with the IME. Reliance did not try to schedule another IME. Instead, Reliance asked Dr. William Scott Hauptman to do an independent review of Glazer's medical records.

In Hauptman's initial review of Glazer's file, he noted that the physical capabilities indicated by Novick in the May 2004 PCQ were of a greater capacity than those indicated in her records from December 2003 and while subsequent records, such as that from Lechner in July 2004, indicated a possible deterioration, for a specific determination Hoffeld would have to obtain more medical records from all medical providers. In closing, Hauptman opined that the "[m]edical records presented for review currently do not provide an objective medical basis upon which to support the patient's increased subjective complaints documented by Dr. Lechner, July 13, 2004." In his second report, after having reviewed additional medical records, Hauptman opined that the physical capacities documented by Novick in May 2004 were consistent with the medical records presented to him through the last office visit, September 29, 2004, with Novick. Hauptman opined that the medical records

did not support the possibility of deterioration and while Glazer presented to Novick with new pain in her finger, such pain did not significantly impact the capacities of her upper extremities as outlined by Novick in May 2004. Hauptman conducted a third review of Glazer's claim in May 2005 after having received additional medical records. Hauptman reviewed medical records through March 2005 and noted that while in February 2005 Glazer had an increase in pain, on March 10, 2005, Glazer reported to Novick that she felt slightly better than her last visit and Novick determined it was not necessary to restart Glazer on the Duragesic patch. In conclusion, Hauptman again found nothing new in Glazer's medical records that negated Novick's May 2004 evaluation of her physical capacities. Based on Hauptman's review and a review by rehabilitation services, Reliance denied Glazer's appeal determining that she "is capable of performing her own occupation."

The Plan includes the following provision under the claims provisions section:

> Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

Reliance was the claims administrator of the Plan and the fiduciary charged with making benefit determinations under the Plan. As a result of this termination of benefits, Glazer brought this action pursuant to the Employee Retirement Income Security Act of 1947 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B).

Legal Standard

Summary judgment is appropriate only when there are no genuine issues of material fact and the movant is entitled to judgment as a matter of law. *See* Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The moving party bears the burden of meeting this exacting standard. *See Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970). In applying this standard, the evidence, and all reasonable factual inferences drawn therefrom, must be viewed in the light most favorable to the non-moving party. *See Arrington v. Cobb County*, 139 F.3d 865, 871 (11th Cir. 1998); *Allen v. Tyson Foods, Inc.*, 121 F.3d 642, 646 (11th Cir. 1997).

The non-moving party, however, bears the burden of coming forward with evidence of each essential element of their claims, such that a reasonable jury could find in their favor. *See Earley v. Champion Int'l Corp.*, 907 F.2d 1077, 1080 (11th Cir. 1990). The non-moving party "[m]ay not rest upon the mere allegations and denials of [its] pleadings, but [its] response . . . must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). "The mere existence of a scintilla of evidence in support of the [non-movant's]

position will be insufficient; there must be evidence on which the jury could reasonably find for the [non-movant]." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986). Further, conclusory, uncorroborated allegations by a plaintiff in an affidavit or deposition will not create an issue of fact for trial sufficient to defeat a well supported summary judgment motion. *See Earley*, 907 F.2d at 1081. The failure of proof concerning an essential element of the non-moving party's case necessarily renders all other facts immaterial and requires the court to grant the motion for summary judgment. *See Celotex*, 477 U.S. at 322.

The burden is on Glazer to prove that she is entitled to the benefits she seeks. *See Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir. 1998). Reviews of ERISA decisions are subject to a very particular and multi-step framework as discussed in *Williams v. BellSouth Telecomm., Inc.*, 373 F.3d 1132, 1137-38 (11th Cir. 2004). The analysis begins with a determination of whether the administrator's decision was "wrong," essentially determining if the Court disagrees with the administrator's decision. *Id.* If the decision was not "wrong," the judicial inquiry is complete and the decision must be affirmed. *Id.* If the decision was wrong, then I must determine if the plan gave the administrator discretion to review claims. *Id.* at 1138. If the plan does not give the administrator discretionary authority to construe the terms of the plan or determine the eligibility for benefits and the decision is wrong, the decision must be reversed. *Id.* On the other hand, if the decision is wrong and the plan granted the administrator

the requisite discretion, the administrator's decision is subject to an arbitrary and capricious standard of review. *Id.* Under this standard of review, the question becomes whether based on the facts known to the administrator at the time, there were reasonable grounds in the record to support its decision. *Id.*; *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1139 (11th Cir. 1989). If no reasonable basis existed, the analysis is complete and the decision must be reversed. *Williams*, 373 F.3d at 1138. If a reasonable basis existed for the decision, the analysis continues to determine if the administrator operated under a conflict of interest. *Id.* Finding no conflict of interest requires affirming the decision. *Id.* Where there is a conflict of interest, the heightened arbitrary and capricious standard is to be employed to review the decision. *Id.* The heightened arbitrary and capricious standard of review is "somewhere between the de novo and 'mere' arbitrary and capricious standards." *Id.* It is under this framework that I analyze Reliance's decision to terminate Glazer's benefits.

Analysis

The parties disagree about the facts surrounding the IME and argue about the situation's impact on Glazer's claim.[1] I do not find it necessary to address that

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1. Reliance argues Glazer failed to exhaust her administrative remedies by refusing to allow the IME to be conducted. Therefore, it argues, Glazer's claim is barred relying on *Zalka v. Unum Life Ins. Co. of America*, 65 F.Supp.2d 1369 (S.D. Fla. 1998). Glazer responds that it is her legal right under

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issue because even on the merits Reliance's motion should be granted. Therefore, I begin my analysis with a discussion of whether Reliance's decision in July 2004 was wrong. For the reasons that follow, I determine Reliance's decision was not wrong.

The record before Reliance supported its decision that Glazer was capable of performing her job. The Plan's definition of total disability was that "an Insured cannot perform the substantial and material duties of his/her regular occupation." Glazer argues that she is disabled under this standard unless she can perform her own job, "as she was performing it prior to her disability." Pl. Opposition at 14. Glazer's own description of her job entailed prolonged repetitive movement, fine manipulation, grasping with both hands, prolonged coordinated eyes, hands, arms, and neck movement, prolonged sitting, twisting, reaching, and carrying. The general definition as outlined by the Department of

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Florida law to have her lawyer present for the IME citing *US. Sec. Inc. Co. v. Cimino*, 754 So.2d 697 (Fla. 2000). Glazer also points out that when Reliance denied her claim, it informed her that she had exhausted her administrative remedies. Reliance disagrees about whether Glazer had an absolute right to be accompanied by her lawyer and a court reporter. It asserts that there is no absolute right because *Cimino* provides that the opposing party can put forth a valid reason, which it had here, when not allowing a claimant to have her attorney present at the IME. Either way, while conducting an IME may be a preferable route in these type of claims, there is no requirement that the administrator complete one. *See Fought v. Unum Life Ins. Co. of America*, 379 F.3d 997, 1015 (10th Cir. 2004).

Labor defined a technical writer's position as one that is sedentary, requiring occasional lifting, carrying, pushing, and pulling of ten pounds, but was mostly sitting and may involve standing or walking for brief periods of time. Under the specific physical demands, the general definition provides for occasional reaching and frequent handling and fingering. The language of the Plan uses the term "regular occupation," which is not defined in the Plan. In such situations it is not uncommon for the administrator to turn to the Dictionary of Occupational Titles published by the Department of Labor. *See Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 271 (4th Cir. 2002); *Richards v. Hartford Life and Accident Ins. Co.*, 356 F.Supp.2d 1278, 1287 (S.D. Fla. 2004). Similar to the employee in *Gallagher*, Glazer fails to point out specific duties that are substantial and material parts of her job which are not included in the DOT definition. *See Gallagher*, 305 F.3d at 272. It does not appear that the two definitions are that far apart. Therefore, Reliance's use of the general definition in evaluating Glazer's claim was not inappropriate.

The analysis now moves on to the evidence in the record regarding Glazer's physical limitations and Reliance's evaluation as to how such physical limitations impacted her ability to perform the substantial and material duties of her occupation. After working with Glazer for a few months, Hoffeld determined that she was not a surgical candidate. Hoffeld's report in October 2003 stated that "[r]ight now there is again no real change in her situation and at least from an orthopedic

sense she is at maximum medical improvement. Whether she will do so with Dr. Novick remains to be seen." In December 2003, Hoffeld completed a PCQ form indicating that the only activities Glazer could frequently do were standing and walking. She could not sit more than occasionally. Hoffeld did not check an exertion level on the PCQ. As to her upper extremities, Hoffeld indicated that Glazer could do no pushing/pulling, and all other tasks she could only do occasionally, such as simple grasping, reaching above mid chest, waist/desk level, fine manipulation, and feeling/tactile sensation. Novick's first impression was cervical spinal stenosis and chronic cervical strain. He planned to treat her with medication, indicated she may need injections, and possibly surgery. Glazer continued seeking treatment with Novick. His treatment continued, trying various medications until determining that she was a candidate for trigger injections. It was after receiving these trigger injections that Glazer reported to Novick feeling better. This coincides with the timing of when Novick completed the PCQ Reliance, at least in part, relied on. The only item Novick's PCQ indicated Glazer was completely restricted from was climbing ladders. On this form, the exertion level question was answered. The form specifically asked what exertion level the patient could work at. Novick responded sedentary lift, which was defined as exerting up to ten pounds of force occasionally, and/or a negligible amount of force frequently. There were no complete restrictions regarding Glazer's upper extremities. The Novick PCQ indicated Glazer could frequently perform simple grasping and fine manipulation and continuously feel

and have tactile sensation. Reaching above mid chest and waist/desk level continued to be restricted to occasionally, as was pulling/pushing, unlike in Hoffeld's PCQ where he said Glazer could not push or pull at all. Novick's notes from his May 2004 visit with Glazer only included one limitation. It was that Glazer not hold her head in one position for a prolonged period of time, taking frequent breaks. At that visit, Novick reported that Glazer was "doing better with the pain, although, she [wa]s frustrated that it [wa]s not completely resolved." Over two months later, Novick saw Glazer again and noted that she remained stable and functional on her current medication regime. Novick's notes indicate Glazer "[wa]s using the treadmill approximately 20 minutes three times per week." Glazer's medical records from Novick's office and Novick's PCQ indicate an improvement in her condition compared to when she was seeing Hoffeld and first stopped working. Given these physical limitations and capacities, it is difficult to determine what substantial and material duty Glazer could not do at her job as a senior technical writer. Glazer's own definition of her job includes prolonged neck movement. Novick did specifically tell her not to keep her neck in one place, but stated that she could take frequent breaks. Glazer does not articulate how taking frequent breaks from holding her neck in one place prohibits her from doing a substantial and material duty of her job.

Glazer also argues that Reliance's decision is wrong where it is based on one document despite voluminous documentation contradicting that document. This

argument is not persuasive. Reliance's decision is supported, not only by the PCQ completed by Novick, but also by his comments of her May and July 2004 visits. Glazer's own treating doctor indicated that she could sit for eight hours a day, do sedentary lifting, and frequently grasp and perform fine manipulation. Glazer was able to drive, perform household duties, and use a treadmill for twenty minutes a day three times a week. The question is not whether there is more evidence supporting Glazer's disability than her lack of disability. The question is whether the decision made by Reliance was wrong. Given Glazer's regular occupation and the medical records presented to Reliance at the time it made its decision, the decision was not wrong.

Glazer brings up two other arguments to cast doubt on Reliance's decision. The first is that Novick never got information about her job. Glazer does not provide any support for the proposition that Novick must receive such information. The PCQ specifically states "[t]he patient can work at the following exertion level(s)." Novick responded by checking the sedentary lift definition. This answer implies that Novick was of the opinion that Glazer could work. Reliance then presented such information to an independent doctor for an evaluation. Hauptman also agreed with Novick's limitations and capacities. This nonexamining doctor's opinion is also considered medical evidence in such cases. *See Gannon v. Metropolitan Life Ins. Co.*, 360 F.3d 211, 214 (1st 2004). Novick indicated, and Hauptman agreed, that Glazer had the ability to perform sedentary work. Reliance was under no obligation to provide Novick with

specific duties of Glazer's job. The other argument Glazer raises is her social security determination. Glazer has been determined totally disabled for social security purposes.[2] The social security decision was made after Reliance made its final decision. Therefore, the Court need not consider it in evaluating Reliance's determination. *See Richards*, 356 F.Supp.2d at 1288. Furthermore, as Reliance points out, while it may consider a social security determination, such determination is not dispositive. *See Whatley v. CNA Ins. Cos.*, 189 F.3d 1310, 1314 n.8 (11th Cir. 1999). Neither of these arguments cast doubt on Reliance's decision. I do not disagree with Reliance's decision.

However, even if Reliance's decision was wrong, it was not arbitrary and capricious, even under the heightened standard.[3] A decision is not to be overturned

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2. Glazer's social security disability application was originally denied. She appealed the decision and in January 2006 a hearing was held before an Administrative Law Judge. The Social Security Administration changed its determination issuing a decision in January 2006. This is some time after Reliance made the decision being reviewed by this Court.

3. Glazer argues that the heightened arbitrary and capricious standard is applicable where Reliance insures the Plan and made the decision. Reliance argues that its decision should be affirmed regardless of what standard of review is applicable. The plan clearly gives Reliance the requisite discretion. However, Reliance is the insurer of the Plan. Therefore, as discussed in *Brown v. Blue Cross and Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1563 (11th Cir. 1990) the modified arbitrary and capricious standard is applicable.

merely because the Court disagrees with the decision. *See Turner v. Delta Family-Care Disability & Surv. Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002)(discussing that "[i]t is irrelevant that the court or anyone else might reach a different conclusion." under the arbitrary and capricious standard of review). The arbitrary and capricious standard of review requires that the administrator's decision not be unreasonable or inconsistent with the record before the administrator. *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1452 (11th Cir. 1997). The heightened arbitrary and capricious standard also requires deference to the administrator's decision, but the review is to be contextually tailored to the facts of the case. *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001). This in between standard of review is somewhere between de novo and arbitrary and capricious. *Williams*, 373 F.3d at 1138. Having determined that I do not find the decision wrong, with the added amount of deference required, even if it is not the same amount required by the arbitrary and capricious standard, the decision would also be affirmed.

There exists a reasonable basis in the record before the administrator that Glazer was able to perform a sedentary job. There is no support in the record that Glazer's job was not a sedentary one. Reliance relied upon the opinion of one of Glazer's own treating doctors and an independent review of her medical records by another doctor. Glazer presents no reason to suspect that Novick's opinion is somehow biased. In fact, the record indicates that Glazer's own lawyer recommended

she see Novick. Glazer points to the determination by Lechner that she it totally disabled. Lechner seems to disagree with Novick. Lechner made such determination on July 13, 2004, one day after Reliance wrote Glazer's letter terminating her benefits. When Lechner made that determination, he had not seen Glazer in over a year. Lechner's determination is at odds with Novick's. This Court's role is not to resolve conflicts between doctors in these cases. The Court must only decide under these particular circumstances whether Reliance's decision was reasonable looking particularly at Glazer's medical records and the requirements of her job. Glazer's arguments do not persuade me that Reliance's decision is incorrect under the heightened arbitrary and capricious standard.

It is

ORDERED AND ADJUDGED that the Defendant's Motion for Summary Judgment (DE 27) is **GRANTED.**

DONE AND ORDERED in Chambers at West Palm Beach, Florida, this 25 day of September, 2006.

s/ Donald M. Middlebrooks
DONALD M. MIDDLEBROOKS
UNITED STATES DISTRICT JUDGE

cc: All Counsel of Record

APPENDIX C — ORDER OF THE UNITED STATES COURT OF APPEALS DENYING PETITION FOR REHEARING FILED JUNE 13, 2008

IN THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

No. 06-15855-BB

PRISCILLA GLAZER,

Plaintiff-Appellant,

versus

RELIANCE STANDARD LIFE INSURANCE COMPANY, a Pennsylvania Corporation,

Defendant-Appellee.

On Appeal from the United States District Court for the Southern District of Florida

ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

Before: BIRCH, PRYOR and KRAVITCH, Circuit Judges.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having

requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

s/ [illegible]
UNITED STATES CIRCUIT JUDGE

APPENDIX D — REGULATION INVOLVED

29 C.F.R. § 2560.503-1

§ 2560.503-1 Claims procedure.

(a) Scope and purpose. In accordance with the authority of [ERISA], 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants) . . . .

* * *

(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

* * *

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

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(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

* * *

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

* * *

(i) Timing of notification of benefit determination on review.

* * *

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access

to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

* * *

(j) (3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other

similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

* * *

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

* * *

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(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information.

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

* * * *